FOR OFFICE USE ONLY					
PC	CP:	XRAY:		Last OR Date:	
D-	forward by a				
RE	ferred by:	MC/NE			
Fa	x:	WC/NF: ADJ:		DOI:	
	···	7.50		26	
1.	1. Describe your chief symptom or problem: Right / Left				
2a.	Location of pain/problem (i.e. groin, inside of knee etc):				
b.	What caused your condition to start? Did you have an injury? Date of injury?				
c.	Symptom Frequency: d.	Symptom Du	ration: e. (Quality of Pain (Check all that apply):	
<u> </u>	Frequently	Days		Sharp	
	Intermittently	Weeks		Dull	
	Constantly	Months		Burning	
	With Activity (Describe):	Years		Aching	
	Other:	Other:		Other:	
		<u></u>			
f.	Please rate the severity or intensity of pain (circle number of pain		5 6 7	8 9 10 Severe	
g.	Factors that make the pain worse (Check all that apply): h. Previous Treatments (Check all that apply, describe where				
	Stairs (Circle one): UP / DOWN		indicated):		
	With first steps, then dissipates		NSAIDs (Ibuprofen, Aleve	, Celebrex, etc):	
	Only after long (30 min) walks		Physical Therapy		
	All Walking		☐ Home Exercise program		
	Prolonged Standing		☐ Injections (type/location?):		
	Sports (Describe):		□ Bracing		
	Other:		☐ Ice application		
_			☐ Walking Aid (Cane, Walker etc):		
			Weight Loss Program		
			Chiropractic care		
			Time of work with rest		
i.	Describe your activity level (Check all that apply):		Other:		
	Bedridden				
	Wheelchair confined				
	Sedentary	j.	Work/Occupation		
	Light Labor		Employed		
	Heavy Labor		Retired		
	Able to perform activities of daily living despite symptoms		Unemployed		
	Unable to perform activities of daily living		Occupation:		
	Sports:				